CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Policy and Operations

(Amended After Comments)

907 KAR 1:055. Payments for primary care center, federally-qualified health center, federally-qualified health center look-alike, and rural health clinic services.

RELATES TO: KRS 205.560, 216B.010, 216B.105, 216B.130, 216B.990, 42 C.F.R. 413, 438.60, 491, Subpart A, 440.130, 440.230, 447.3251, 45 C.F.R. 74.27, 48 C.F.R. Part 31, 42 U.S.C. 1396a, b, d

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560(1), 216B.042, 42 U.S.C. 1396a

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the Department for Medicaid Services' reimbursement policies for primary care center, federally-qualified health center, federally-qualified health center look-alike, and rural health clinic services.

Section 1. Definitions. (1) "Advanced practice registered nurse" or "APRN" is defined by KRS 314.011(7).

(2) "Alternative payment methodology" or "APM" means a reimbursement that is an alternative to the standard reimbursement established in Section 3 of this administrative regulation in accordance with 42 U.S.C. 1396a(bb)(6)[~~"Allowable costs" means costs that are incurred by a federally qualified health center, federally qualified health center look-alike, rural health clinic, or primary care center that are reasonable in amount and proper and necessary for the efficient delivery of services~~].

(3) "Audit" means an examination that[~~, which~~] may be full or limited in scope[~~,~~] of a federally-qualified health center's, federally-qualified health center look-alike's, rural health clinic's, or primary care center's:

(a) Financial transactions, accounts, and reports; and

(b) Compliance with applicable Medicare and Medicaid regulations, manual instructions, and directives.

(4) "Base year" means the first full fiscal year following the effective date of an FQHC's, FQHC look-alike's, or RHC's enrollment in the Medicaid program:

(a) In which the FQHC, FQHC look-alike, or RHC has reached its maximum hours per day, days per week, and weeks per year of intended operation **as designated by the FQHC, FQHC look-alike, or RHC; and**

(b) Not to exceed twenty-four (24) months past the effective date that the FQHC, FQHC look-alike, or RHC was enrolled with the department.

(5) "Certified psychologist with autonomous functioning" means an individual who is a certified psychologist with autonomous functioning pursuant to KRS 319.056.

(6) "Certified social worker" means an individual who meets the requirements established in KRS 335.080.

(7) "Change in scope of service" means a change in the type, intensity, duration, or amount of service.

(8)[~~(5) "Clinical psychologist" is defined by 42 C.F.R. 410.71(d).~~

~~(6)~~] "Department" means the Department for Medicaid Services or its designated agent.

(9)[~~(7)~~] "Enrollee" means a recipient who is enrolled with a managed care organization for the purpose of receiving Medicaid or KCHIP covered services.

(10)[~~(8)~~] "Federal financial participation" is defined in 42 C.F.R. 400.203.

(11)[~~(9)~~] "Federally-qualified health center" or "FQHC" is defined in 42 C.F.R. 405.2401.

(12)[~~(10)~~] "Federally-qualified health center look-alike" or "FQHC look-alike" means an entity that is currently approved by the United States Department of Health and Human Services, Health Resources and Services Administration, and the Centers for Medicare and Medicaid Services to be a federally-qualified health center look-alike.

(13) "Final PPS rate" means an all-inclusive reimbursement amount per visit for an FQHC, FQHC look-alike, or RHC that:

(a) Is unique to the FQHC, FQHC look-alike, or RHC;

(b) Encompasses reimbursement for all services rendered during the visit;

(c) Is based on:

1. Twelve (12) full months of Medicaid cost report data in which the FQHC, FQHC look-alike, or RHC has reached its maximum hours per day, days per week, and weeks per year of intended operation:

a. Submitted to the department by the FQHC, FQHC look-alike, or RHC; and

b. That has been reviewed and approved by the department; and

2. A paid claims listing corresponding to the twelve (12) full months of Medicaid cost report data in which the FQHC, FQHC look-alike, or RHC has reached its maximum hours per day, days per week, and weeks per year of intended operation; and

(d) Is established by the department.

(14)[~~(11)~~] "Health care provider" means, for:

(a) A primary care center, an FQHC, an FQHC look-alike, or an RHC:

1. A licensed physician;

2. A licensed osteopathic physician;

3. A licensed podiatrist;

4. A licensed optometrist;

5. An[~~A licensed or certified~~] advanced practice registered nurse;

6. A licensed dentist or oral surgeon;

7. A physician assistant;

8. A licensed clinical social worker;[~~or~~]

9. A licensed[~~clinical~~] psychologist;

10. A licensed marriage and family therapist;

11. A licensed professional clinical counselor;

12. A licensed psychological practitioner;

13. A certified psychologist with autonomous functioning; or

14. A practitioner authorized pursuant to 907 KAR 1:054 to provide services in a PCC, an FQHC, an FQHC look-alike, or an RHC who is not listed in subparagraphs 1 through 13 of this paragraph; or

(b)[~~An FQHC, FQHC look-alike, or RHC:~~

~~1. A provider or practitioner listed in paragraph (a) of this subsection; or~~

~~2. Contingent upon approval of a state plan amendment by the Centers for Medicare and Medicaid Services, a:~~

~~a. Licensed professional clinical counselor; or~~

~~b. Licensed marriage and family therapist; or~~

~~(c)~~] An FQHC or FQHC look-alike, in addition to the professionals established in paragraph (a) of this subsection:

1. A resident in the presence of a teaching physician; or

2. A resident without the presence of a teaching physician if:

a. The services are furnished in an FQHC or FQHC look-alike in which the time spent by the resident in performing patient care is included in determining any intermediary payment to a hospital in accordance with 42 C.F.R. 413.75 through 413.83;

b. The resident furnishing the service without the presence of a teaching physician has completed more than six (6) months of an approved residency program;

c. The teaching physician:

(i) Does not direct the care of more than four (4) residents at any given time; and

(ii) Directs care from a proximity that constitutes immediate availability; and

d. The teaching physician:

(i) Has no other responsibilities at the time;

(ii) Has management responsibility for any recipient seen by the resident;

(iii) Ensures that the services furnished are appropriate;

(iv) Reviews with the resident, during or immediately after each visit by a recipient,

the recipient's medical history, physical examination, diagnosis, and record of tests or therapies; and

(v) Documents the extent of the teaching physician's participation in the review and direction of the services furnished to each recipient.

(15)[~~(12)~~] "Interim PPS rate" means an all-inclusive per visit[a] reimbursement amount established by the department to pay an FQHC, FQHC look-alike, or an RHC[~~, or a PCC~~] for covered services prior to the establishment of a final PPS rate.

(16)[~~(13)~~] "Licensed clinical social worker" means an individual who is currently licensed in accordance with KRS 335.100.

(17)[~~(14)~~] "Licensed marriage and family therapist" is defined by KRS 335.300(2).

(18)[~~(15)~~] "Licensed professional clinical counselor" is defined by KRS 335.500(3).

(19) "Licensed psychological practitioner" means an individual who meets the requirements established in KRS 319.053.

(20)[~~(16)~~] "Managed care organization" means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined in 42 C.F.R. 438.2.

(21) "Medical Group Management Association Medical Directorship and On-Call Compensation Survey" means a report developed and owned by the Medical Group Management Association that:

(a) Highlights the critical relationship between medical director compensation and time spent in the medical director function;

(b) Aligns medical director compensation with time spent as medical director; and

(c) Contains tables illustrating the relationship of medical director salary to time spent

in the medical director function.

(22)[~~(17)~~] "Medical Group Management Association Physician Compensation and Production Survey Report" means a report developed and owned by the Medical Group Management Association that[~~which~~]:

(a) Highlights the critical relationship between physician salaries and productivity;

(b) Is used to align physician salaries and benefits with provider production; and

(c) Contains:

1. Performance ratios illustrating the relationship between compensation and production; and

2. Comprehensive and summary data tables that cover many specialties.

(23)[~~(18)~~] "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(24)[~~(19)~~] "Medicare Economic Index" or "MEI" means the economic index referred to in 42 U.S.C. 1395u(b)(3)(L).

(25) "Paid claims listing" means a report of claims paid by the department for a given FQHC, FQHC look-alike, or RHC.

(26)[~~(20)~~] "Parent facility" means a federally-qualified health center, federally-qualified health center look-alike, or primary care center that is:

(a) Licensed and operating with a unique Kentucky Medicaid program provider number;

(b) Operating under the same management as a satellite facility; and

(c) The original facility which existed prior to the existence of a satellite facility.

(27)[~~(21)~~] "PCC" or "primary care center" means an entity that is currently licensed as

a PCC in accordance with 902 KAR 20:058.

(28)[~~(22)~~] "Percentage increase in the MEI" is defined in 42 U.S.C. 1395u(i)(3).

(29)[~~(23)~~] "Physician assistant" is defined by KRS 311.840(3).

(30)[~~(24)~~] "PPS" means prospective payment system.

(31)[~~(25)~~] "Rate year" means, for the purposes of the MEI, the twelve (12) month period beginning July 1 of each year for which a rate is established for an FQHC, FQHC look-alike, or RHC[~~, or a PCC~~] under the prospective payment system.

(32)[~~(26)~~] "Reasonable cost" means:

(a) A cost as determined by the:

1.[~~(a)~~] Applicable Medicare cost reimbursement principles established in 42 C.F.R. Part 413, 45 C.F.R. 74.27, and 48 C.F.R. Part 31; and

2.[~~(b)~~] Medical Group Management Association Physician Compensation and Production Survey Report for the applicable year and region; and

(b) Costs determined to be reasonable in accordance with a comprehensive desk review or audit.

(33)[~~(27)~~] "Recipient" is defined by KRS 205.8451(9).

(34)[~~(28)~~] "RHC" or "rural health clinic" is defined in 42 C.F.R. 405.2401(b).

(35)[~~(29)~~] "Satellite facility" means a federally-qualified health center, federally-qualified health center look-alike, or primary care center that:

(a) Is at a different location than the parent facility; and

(b) Operates under the same management as the parent facility.

(36)[~~(30)~~] "Telehealth" means two (2)-way, real time interactive communication between a patient and a physician or practitioner located at a distant site for the purpose

of improving a patient's health through the use of interactive telecommunication equipment that includes, at a minimum, audio and video equipment.

(37)[~~(31)~~] "Visit" means an[~~a face-to-face~~] encounter:

(a)[~~or encounter which occurs via Telehealth~~] Between a recipient or enrollee and a health care provider during which an FQHC, FQHC look-alike, or RHC service is delivered; and

(b) Which occurs:

1. In person; or

2. Via telehealth if authorized by 907 KAR 3:170.

Section 2. Provider Participation Requirements. (1)(a) A participating FQHC, FQHC look-alike, RHC, or PCC shall be currently:

1. Enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672; and

2. Except as established in paragraph (c) of this subsection, participating in the Kentucky Medicaid program in accordance with 907 KAR 1:671.

(b) A satellite facility of an FQHC, an FQHC look-alike, or a PCC shall:

1. Be currently listed on the parent facility's license in accordance with 902 KAR 20:058;

2. Comply with the requirements regarding extensions established in 902 KAR 20:058; and

3. Comply with 907 KAR 1:671.

(c) In accordance with 907 KAR 17:015, Section 3(3), an FQHC, FQHC look-alike, RHC, or PCC that provides a service to an enrollee shall not be required to be currently

participating in the fee-for-service Medicaid Program.

(2)(a) To be initially enrolled with the department, an:

1. FQHC or[,] FQHC look-alike[, ~~or RHC~~] shall:

a.[~~1.~~] Enroll in accordance with 907 KAR 1:672; and

b.[~~2.~~] Submit to the department proof of its FQHC or FQHC look-alike designation issued by the Centers for Medicare and Medicaid Services; or

2. RHC shall:

a. Enroll in accordance with 907 KAR 1:672; and

b. Submit to the department proof of its RHC license issued by the Cabinet for Health and Family Services Office of Inspector General[~~certification by the United States Department of Health and Human Services, Health Resources and Services Administration as an FQHC, FQHC look-alike, or RHC~~].

(b) To remain enrolled and participating in the Kentucky Medicaid program, an:

1. FQHC or[,] FQHC look-alike[, ~~or RHC~~] shall:

a.[~~1.~~] Comply with the enrollment requirements established in 907 KAR 1:672;

b.[~~2.~~] Comply with the participation requirements established in 907 KAR 1:671; and

c.[~~3.~~] Annually submit to the department proof of its FQHC or FQHC look-alike designation issued by the Centers for Medicare and Medicaid Services; or

2. RHC shall:

a. Comply with the enrollment requirements established in 907 KAR 1:672;

b. Comply with the participation requirements established in 907 KAR 1:671; and

c. Annually submit to the department proof of its RHC license issued by the Cabinet for Health and Family Services Office of Inspector General[~~certification by the United~~

~~States Department of Health and Human Services, Health Resources and Services Administration as an FQHC, FQHC look-alike, or RHC to the department~~].

(c) The requirements established in paragraphs (a) and (b) of this subsection shall apply to a satellite facility of an FQHC or FQHC look-alike.

(3)(a) An FQHC or[,] FQHC look-alike[~~, or PCC~~] that operates multiple satellite facilities shall:

1.[~~(a)~~] List each satellite facility on the parent facility's license in accordance with 902 KAR 20:058; and

2.[~~(b)~~] Consolidate claims and cost report data of its satellite facilities with the parent facility.

(b) A PCC that operates multiple satellite facilities shall list each satellite facility on the parent facility's license in accordance with 902 KAR 20:058.

(4) An FQHC, FQHC look-alike, RHC, or PCC that has been terminated from federal participation shall be terminated from Kentucky Medicaid program participation.

(5) A participating:

(a) FQHC and its staff shall comply with all applicable federal laws and regulations, state laws and administrative regulations, and local laws and regulations regarding the administration and operation of an FQHC;

(b) FQHC look-alike and its staff shall comply with all applicable federal laws and regulations, state laws and administrative regulations, and local laws and regulations regarding the administration and operation of an FQHC look-alike;

(c) RHC and its staff shall comply with all applicable federal laws and regulations, state laws and administrative regulations, and local laws and regulations regarding the

administration and operation of an RHC; or

(d) PCC and its staff shall comply with all applicable federal laws and regulations, state laws and administrative regulations, and local laws and regulations regarding the administration and operation of a PCC[~~PPC~~].

(6) An FQHC, FQHC look-alike, RHC, or PCC performing laboratory services shall meet the requirements established in 907 KAR 1:028 and 907 KAR 1:575.

Section 3. Standard Reimbursement for an FQHC, FQHC look-alike, or RHC for a Visit by a Recipient Who is not an Enrollee and that is Covered by the Department. (1) Except as established in Section 5 or Section 9 of this administrative regulation, for a visit by a recipient who is not an enrollee and that is covered by the department, the department shall reimburse:

(a) An FQHC, FQHC look-alike, or RHC a final PPS rate[~~an all-inclusive encounter rate per patient visit in accordance with a prospective payment system (PPS)~~] as required by 42 U.S.C. 1396a(bb)[~~1396a(aa)~~]; or

(b) A satellite facility of an FQHC or FQHC look-alike a final PPS rate[~~an all-inclusive encounter rate per patient visit in accordance with a prospective payment system (PPS)~~] as required by 42 U.S.C. 1396a(bb)[~~1396a(aa)~~].

(2) Costs related to outpatient drugs or pharmacy services shall be excluded from the PPS rate[~~all-inclusive encounter rate per patient visit~~] referenced in subsection (1) of this section.

(3) The department shall calculate a final PPS rate for a new FQHC, FQHC look-alike, or RHC in accordance with Section 4 of this administrative regulation.

(4) The department shall adjust a final PPS rate[~~per visit~~]:

(a) By the percentage increase in the MEI applicable to FQHC, FQHC look-alike, or RHC services on July 1 of each year;[~~and~~]

(b) In accordance with Section 10[~~8~~] of this administrative regulation:

1. Upon request and documentation by an FQHC, FQHC look-alike, or RHC that there has been a change in scope of services; or

2. Upon review and determination by the department that there has been a change in scope of services; and

(c) If necessary as a result of a desk review or audit.

(5) A final PPS rate established in accordance with this administrative regulation shall not be subject to an end of the year cost settlement.

Section 4. Establishment of a Final PPS Rate for a New FQHC, FQHC look-alike, or RHC.

(1)(a) The department shall establish a final PPS rate to reimburse a new FQHC, FQHC look-alike, or RHC 100 percent of its reasonable cost of providing Medicaid covered services utilizing information from[~~during~~] the FQHC's, FQHC look-alike's, or RHC's base year upon completion of a comprehensive desk review or audit of an FQHC's, FQHC look-alike's, or RHC's Universal Cost Report.

(b) Except for a time frame in which the department reimburses an FQHC, FQHC look-alike, or RHC an interim PPS rate, the[~~initial and subsequent~~] final PPS rate established for an FQHC, FQHC look-alike, or RHC shall:

1. Be prospective; and

2. Not settled to cost.

(2)[~~(a)~~] The department shall determine the reasonable costs of an FQHC, FQHC

look-alike, or RHC based on the:

(a) Universal Cost Report:

1. Submitted by the FQHC, FQHC look-alike, or RHC to the department and prepared by the FQHC, FQHC look-alike, or RHC in accordance with the Universal Cost Report Instructions; and

2. That[~~which~~] contains twelve (12) full months of operating data for the **designated base [~~first full fiscal~~]** year **[~~of operations that the FQHC, FQHC look-alike, or RHC has reached its maximum hours per day, days per week, and weeks per year of intended operation~~]**;

(b) Department's review of the Universal Cost Report referenced in paragraph (a) of this subsection; and

(c) Costs and visits as adjusted by the department for full-time operation for a facility that is not in operation at least forty (40) hours per week[~~most recently submitted to the department by the FQHC, FQHC look-alike, or RHC.~~

~~(b) The base rate referenced in subsection (1)(a) of this section shall be based on the reasonable cost determination made by the department pursuant to paragraph (a) of this subsection~~].

(3)(a)[~~Until an FQHC, FQHC look-alike, or RHC submits a Medicaid cost report containing twelve (12) full months of operating data for the facility's base year, the department shall reimburse the FQHC, FQHC look-alike, or RHC an interim rate equal to the all-inclusive per visit rate established for the FQHC, FQHC look-alike, or RHC by Medicare.~~

~~(b) An FQHC, FQHC look-alike, or RHC shall provide the department with a copy of~~

~~the Medicare rate letter for the rates in effect during the FQHC's, FQHC look-alike's, or RHC's interim period.~~

~~(c)1. The department shall adjust an interim rate for an FQHC, FQHC look-alike, or RHC based on the establishment of the final rate.~~

~~2. All claims submitted to the department and paid by the department based on the interim rate shall be adjusted to comport with the final rate.~~

~~(4)(a)~~] An FQHC, FQHC look-alike, or RHC shall submit a Universal Cost Report to the department by the end of the fifth month following the end of the FQHC's, FQHC look-alike's, or RHC's **designated base** [~~**first full fiscal**~~] year [~~**that the FQHC, FQHC look-alike, or RHC has reached its maximum hours per day, days per week, and weeks per year of intended operation**~~].

(b) The department shall:

1. Review the Universal Cost Report referenced in paragraph (a) of this subsection submitted by an FQHC, FQHC look-alike, or RHC within ninety (90) business days of receiving the Universal Cost Report; and

2. Notify the FQHC, FQHC look-alike, or RHC of the[~~:~~

~~a.~~] necessity of the FQHC, FQHC look-alike, or RHC to submit additional documentation if necessary[~~;~~

~~b. Final rate established;~~

~~c. Appeal rights regarding the final rate; and~~

~~d. Estimated time for determining a final rate if a final rate is not established within ninety (90) days~~].

(c)1. If additional documentation is necessary to establish a final PPS rate, the

FQHC, FQHC look-alike, or RHC shall:

a. Provide the additional documentation to the department within thirty (30) days of the notification of need for additional documentation; or

b. Request an extension beyond thirty (30) days to provide the additional documentation.

2. The department shall grant no more than one (1) extension.

3. An extension shall not exceed thirty (30) days.

(d)1. If the department requests additional documentation from an FQHC, FQHC look-alike, or RHC but does not receive additional documentation or an extension request within thirty (30) days, the department shall reimburse the FQHC, FQHC look-alike, or RHC **as it reimburses primary care centers that are not an FQHC, FQHC look-alike, or RHC pursuant to Section 7 of this administrative regulation [based on the Medicaid physician fee schedule applied to physician services pursuant to 907 KAR 3:010]** until:

a.[1.] The additional documentation has been received by the department; and

b.[2.] The department has established a final PPS rate.

2. If an FQHC, FQHC look-alike, or RHC does not submit a Universal Cost Report to the department, the department shall reimburse the FQHC, FQHC look-alike, or RHC **as it reimburses primary care centers that are not an FQHC, FQHC look-alike, or RHC pursuant to Section 7 of this administrative regulation [based on the Medicaid physician fee schedule applied to physician services pursuant to 907 KAR 3:010]** until the FQHC, FQHC look-alike, or RHC submits a Universal Cost Report to the department.

(e) The department shall review an FQHC's, FQHC look-alike's, or RHC's paid claims listing for the period of time corresponding to the FQHC's, FQHC look-alike's, or RHC's cost report period of time referenced in paragraph (a) of this subsection.

(f)1. If an FQHC, FQHC look-alike, or RHC has submitted all necessary information to the department, within forty-five (45) days of reviewing the FQHC's, FQHC look-alike's, or RHC's paid claims listing, the department shall:

a. Establish a final PPS rate for the FQHC, FQHC look-alike, or RHC; and

b. Notify the FQHC, FQHC look-alike, or RHC in writing of the FQHC's, FQHC look-alike's, or RHC's:

(i) Final PPS rate; and

(ii) Appeal rights regarding the PPS final rate.

2. To allow adequate time for claim adjudication, a paid claims listing shall not be requested until at least fourteen (14) months after an FQHC's, FQHC look-alike's, or RHC's fiscal year end.

3. If an FQHC, FQHC look-alike, or RHC has not submitted all necessary information to the department to establish a final PPS rate, the department shall continue to pay the FQHC, FQHC look-alike, or RHC **as it pays primary care centers that are not an FQHC, FQHC look-alike, or RHC pursuant to Section 7 of this administrative regulation [~~based on the Medicaid physician fee schedule applied to physician services pursuant to 907 KAR 3:010~~].**

(4) Along with a Universal Cost Report, an FQHC, FQHC look-alike, or RHC shall submit to the department a written statement of the FQHC's, FQHC look-alike's, or RHC's maximum hours per day, days per week, and weeks per year of operation.

Section 5. Interim Reimbursement for a New FQHC, FQHC Look-alike, or RHC.

(1)(a) Until a final PPS rate is established for an FQHC, FQHC look-alike, or RHC, the department shall reimburse the FQHC, FQHC look-alike, or RHC an interim PPS rate based on the average final PPS rates of entities with similar caseloads.

(b) To identify an entity with a similar caseload, the department shall consider:

1. Entity type (FQHC, FQHC look-alike, or RHC);

2. Managed care organization region;

3. Operating hours per day, days per week, and weeks per year; and

4. Specialty services, obstetrical services, or hospital-based entities, if applicable.

(2) If no entity with a similar caseload exists, the department shall establish an interim PPS rate using cost reporting methods.

(3) After the department establishes a final PPS rate for an FQHC, FQHC look-alike, or RHC, the department shall retroactively adjust reimbursement to the FQHC, FQHC look-alike, or RHC that was made on an interim basis to comport with the final PPS rate.

(4) An FQHC, FQHC look-alike, or RHC, upon enrolling with the Medicaid Program, shall submit in writing to the department a statement stating the FQHC's, FQHC look-alike's, or RHC's maximum hours per day, days per week, and weeks per year of operation.

Section 6. Reimbursement for Services or Drugs Provided to an Enrollee by a PCC That is Not an FQHC, FQHC Look-Alike, or RHC and that are Covered by an MCO. (1) For a service or drug provided to an enrollee by a PCC that is not an FQHC, FQHC look-alike, or RHC and that is covered by an MCO, the PCC's reimbursement shall be the reimbursement established pursuant to an agreement between the PCC and the

managed care organization with whom the enrollee is enrolled.

(2) The department shall not supplement the reimbursement referenced in subsection (1) of this section.

Section 7.[~~6.~~] Reimbursement for Services or Drugs Provided to a Recipient by a PCC That is Not an FQHC, FQHC Look-Alike, or RHC and that are Covered by the Department. (1)(a) For a service or drug provided to a recipient that is not an enrollee by a PCC that is not an FQHC, FQHC look-alike, or RHC, the department shall reimburse the rate or reimbursement established for the service or drug on the current Kentucky-specific Medicare Physician Fee Schedule[~~established for Kentucky~~].

(b)1. If no rate or reimbursement exists on the Kentucky-specific Medicare Physician's Fee schedule for a service or drug referenced in paragraph (a) of this subsection, the department shall reimburse for the service or drug the same amount that the department reimburses for the service or drug pursuant to the applicable administrative regulation established in Title 907 KAR.

2. For example, if no reimbursement exists on the current Kentucky-specific Medicare Physician Fee Schedule for a:

a. Dental service, the department shall reimburse for the dental service pursuant to 907 KAR 1:626; **or**

b. Given physician's service, the department shall reimburse for the service pursuant to 907 KAR 3:010.

3. The department shall reimburse a rate equal to seventy-five (75) percent of the rate it pays a physician pursuant to 907 KAR 3:010 for a physician's service that:

a. Does not exist on the current Kentucky-specific Medicare Physician Fee Schedule; and

b. Is provided by an APRN or physician assistant.

(2) The reimbursement referenced in subsection (1) of this section shall not exceed the federal upper payment limit determined in accordance with 42 C.F.R. 447.321.

(3)(a) The coverage provisions and requirements established in 907 KAR 3:005[~~1:054~~] shall apply to a service or drug provided by a PCC.

(b) If a Medicare coverage provision or requirement exists regarding a given service or drug that contradicts a provision or requirement established in 907 KAR 3:005[~~1:054~~], the provision or requirement established in 907 KAR 3:005[~~1:054~~] shall supersede the Medicare provision or requirement.

Section 8.[~~7.~~] Supplemental Reimbursement for FQHC Visits, FQHC Look-Alike Visits, and RHC Visits. If a managed care organization's reimbursement to an FQHC, FQHC look-alike, or RHC for a visit by an enrollee to the FQHC, FQHC look-alike, or RHC is less than what the FQHC, FQHC look-alike, or RHC would receive pursuant to Sections 3,[~~and~~] 4, 5, or 9 of this administrative regulation, the department shall supplement the reimbursement made by the managed care organization in a manner that:

(1) Equals the difference between what the managed care organization reimbursed and what the reimbursement would have been if it had been made in accordance with Sections 3,[~~and~~] 4, 5, or 9 of this administrative regulation;

(2) Is in accordance with 42 U.S.C. 1396a(bb)(5)(A); and

(3) Ensures that total reimbursement does not exceed the federal upper payment limit in accordance with[~~:~~

~~(a)~~] 42 C.F.R. 447.304[~~; and~~

~~(b) 42 C.F.R. 447.321~~].

Section 9. Alternative Payment Methodology for an FQHC, FQHC Look-alike, or RHC.

(1)(a) The department shall pay to an FQHC, FQHC look-alike, or RHC, for which a final PPS rate exists, an alternative payment methodology if the FQHC, FQHC look-alike, or RHC notifies the department in writing that it requests to receive the alternate reimbursement.

(b)1. The APM shall equal 125 percent of the Medicare upper payment limit for rural health clinics in effect on September 30, 2014.

2. The APM referenced in subparagraph 1 of this paragraph shall not be adjusted for inflation.

(c) An FQHC, FQHC look-alike, or RHC that had an interim PPS rate prior to November 1, 2015 may request the APM as an interim PPS rate until the FQHC's, FQHC look-alike's, or RHC's final PPS rate is established.

(2)(a) An APM established in this section shall be effective for dates of service beginning with the date requested in writing by an FQHC, FQHC look-alike, or RHC except as established in paragraph (b) of this subsection.

(b) An APM effective date shall not precede the date in which the department received the written request for the APM.

Section 10.[~~8.~~] Change in Scope and Final PPS Rate Adjustment. (1)(a) If an FQHC, FQHC look-alike, or RHC changes its scope of services after the base year, the department shall adjust the FQHC's, FQHC look-alike's, or RHC's final PPS rate if the

change in scope qualifies for an adjustment in accordance with this section upon departmental review and approval of the change in scope.

(b) An adjustment to a final PPS rate resulting from a change in scope that occurred after an FQHC's, FQHC look-alike's, or RHC's base year shall be[~~retroactively~~] effective to the date that the[~~FQHC, FQHC look-alike, or RHC applied for the~~] change in scope occurred.

(c)1. A revised PPS rate shall be calculated in accordance with the MAP 100501.

2. There shall be no rebasing regarding a revised PPS rate.

(2) A change in scope of service shall be restricted to:

(a) Adding or deleting a covered service;

(b) Increasing or decreasing the intensity of a covered service pursuant to subsection (5) of this section; or

(c) A statutory or regulatory change that materially impacts the costs or visits of an FQHC, FQHC look-alike, or RHC.

(3) The following items individually shall not constitute a change in scope:

(a) A general increase or decrease in the costs of existing services;

(b) A reduction or an expansion of[~~office~~] hours per day, days per week, or weeks per year;

(c) An addition of a new site that provides the same Medicaid covered services;

(d) A wage increase;

(e) A renovation or other capital expenditure;

(f) A change in ownership; or

(g) An addition or deletion of a service provided by a non-licensed professional or

specialist.

(4)(a) An addition of a covered service shall be restricted to the addition of a licensed professional staff member who can perform a Medicaid covered service that is not currently being performed within the FQHC, FQHC look-alike, or RHC by a licensed professional employed or contracted by the facility.

(b) The deletion of a covered service shall be restricted to the deletion of a licensed professional staff member who can perform a Medicaid covered service that was being performed within the FQHC, FQHC look-alike, or RHC by the licensed professional staff member.

(5) A change in intensity shall:

(a) Include a material change;

(b) Increase or decrease the existing final PPS rate by at least five (5) percent; and

(c) Last at least twelve (12) months.

(6) The department shall consider a change in scope request due to a statutory or regulatory change that materially impacts the costs of visits at an FQHC, FQHC look-alike, or RHC if:

(a) A government entity imposes a mandatory minimum wage increase and the increase was:

1. Not included in the calculation of the final PPS rate; or

2. Subsequently included in the MEI applied yearly; or

(b)1. A new licensure requirement or modification of an existing requirement by the state results in a change that affects all facilities within the class.

2. A provider shall document that an increase or decrease in the cost of a visit oc-

curred as a result of a licensure requirement or policy modification.

(7) A requested change in scope shall:

(a) Increase or decrease the existing final PPS rate by at least five (5) percent;[~~and~~]

(b) Last at least twelve (12) months; and

(c) Be submitted to the department in writing.

(8)(a) An FQHC, FQHC look-alike, or RHC that requests a change in scope shall submit[~~For a change in scope that is effective during a base year for determining an FQHC's, FQHC look-alike's, or RHC's final PPS rate, the base year costs associated with the change in scope shall not be duplicated when determining the revised PPS rate due to the change in scope.~~

~~(9)~~] the following documents[~~shall be submitted~~] to the department within six (6) months of the requested effective date of a change in scope:

1.[~~(a)~~] A narrative describing the change in scope;

2.[~~(b)~~] **[~~A projected Universal Cost Report containing twelve (12) months of projected cost report data for the interim PPS rate change;~~**

~~3.~~][~~and (c)~~] A completed MAP 100501, Prospective Payment System Rate Adjustment, completed according to the Instructions for Completing the MAP 100501 Form; and

3.[~~4.~~] A signed letter requesting the change in scope.

(b) If the department does not receive the documentation required regarding a change in scope within six (6) months after the requested effective date of a change in scope, the change in scope shall be denied.

(c)1.[~~(10)~~] The department shall:

a.[~~(a)~~] Review the documentation listed in this subsection[~~(9) of this section~~]; and

b.[~~(b)~~] Notify the FQHC, FQHC look-alike, or RHC in writing of the:

(i) Approval or denial of the request for change in scope within ninety (90) business days from the date the department received the request; or

(ii) Need for additional documentation from the FQHC, FQHC look-alike, or RHC to establish **an [~~a PPS~~]** interim PPS rate associated with the change in scope.

2.[~~(11)(a)~~] If the department requests additional documentation to calculate the interim PPS rate for a change in scope, the FQHC, FQHC look-alike, or RHC shall:

a.[~~1.~~] Provide the additional documentation to the department within thirty (30) days of the notification of need for additional documentation; or

b.[~~2.~~] Request an extension beyond thirty (30) days to provide the additional documentation.

3.a.[~~(b)1.~~] The department shall grant no more than one (1) extension.

b.[~~2.~~] An extension shall not exceed thirty (30) days.

4. If the department approves the request for a change in scope and receives all of the necessary documentation from an FQHC, FQHC look-alike, or RHC within the timelines established in this section, the department shall establish an interim PPS rate for the FQHC, FQHC look-alike, or RHC based on the projected costs contained in the **completed MAP 100501, Prospective Payment System Rate Adjustment [~~Universal Cost Report~~]** referenced in paragraph (a)2 of this subsection.

(9)(a) To establish a PPS final rate resulting from a change in scope, the department shall use a **completed MAP 100501, Prospective Payment System Rate Adjustment and** Universal Cost Report submitted by the FQHC, FQHC look-alike, or RHC to the

department that contains twelve (12) months of cost data **for the first full fiscal year end after [~~beginning with~~]** the effective date of the change in scope.

(b) Within six (6) months of the end of the twelve (12) month cost data period referenced in paragraph (a) of this subsection, the FQHC, FQHC look-alike, or RHC shall submit to the department the **completed MAP 100501, Prospective Payment System Rate Adjustment and** Universal Cost Report containing cost data corresponding to the twelve (12) month cost data **for the first full fiscal year end after the effective date of [~~period associated with~~]** the change in scope.

(c) The department shall:

1. Review the **completed MAP 100501, Prospective Payment System Rate Adjustment and** Universal Cost Report referenced in paragraph (a) of this subsection submitted by an FQHC, FQHC look-alike, or RHC within ninety (90) business days of receiving the **completed MAP 100501, Prospective Payment System Rate Adjustment and** Universal Cost Report; and

2. Notify the FQHC, FQHC look-alike, or RHC of the necessity of the FQHC, FQHC look-alike, or RHC to submit additional documentation if necessary.

(d)1. If additional documentation is necessary to establish a PPS final rate, the FQHC, FQHC look-alike, or RHC shall:

a. Provide the additional documentation to the department within thirty (30) days of the notification of need for additional documentation; or

b. Request an extension beyond thirty (30) days to provide the additional documentation.

2. The department shall grant no more than one (1) extension.

3. An extension shall not exceed thirty (30) days.

(e)1. If the department requests additional documentation from an FQHC, FQHC look-alike, or RHC but does not receive additional documentation or an extension request within thirty (30) days, the department shall reimburse the FQHC, FQHC look-alike, or RHC the FQHC's, FQHC look-alike's, or RHC's PPS final rate that was in effect prior to the FQHC's, FQHC look-alike's, or RHC's request for a change in scope until:

a. The additional documentation has been received by the department; and

b. The department establishes a new final PPS rate associated with the change in scope.

2. If an FQHC, FQHC look-alike, or RHC does not submit a **completed MAP 100501, Prospective Payment System Rate Adjustment and** Universal Cost Report to the department in accordance with paragraph (b) of this subsection, the department shall:

a. Not issue a new PPS final rate associated with the change in scope; and

b. Revert to paying the **FQHC [~~FHQC~~]**, FQHC look-alike, or RHC the FQHC's, FQHC look-alike's, or RHC's PPS final rate that was in effect prior to the FQHC, FQHC look-alike, or RHC requesting a change in scope.

(f)1. If any service included in a change in scope is a service that can be identified on a paid claims listing, the department shall review the FQHC's, FQHC look-alike's, or RHC's paid claims listing for the period of time corresponding to the FQHC's, FQHC look-alike's, or RHC's cost report period of time referenced in paragraphs (a) and (b) of this subsection.

2. If an FQHC, FQHC look-alike, or RHC has submitted all necessary information to the department, within forty-five (45) days of reviewing the FQHC's, FQHC look-alike's,

or RHC's paid claims listing, the department shall:

a. Establish a final PPS rate, resulting from the change in scope, for the FQHC, FQHC look-alike, or RHC; and

b. Notify the FQHC, FQHC look-alike, or RHC in writing of the FQHC's, FQHC look-alike's, or RHC's:

(i) Final PPS rate; and

(ii) Appeal rights regarding the PPS final rate.

3. To allow adequate time for claim adjudication, a paid claims listing shall not be requested until at least fourteen (14) months after the end of the FQHC's, FQHC look-alike's, or RHC's cost report period associated with the change in scope.

(g)1. If no service included in a change in scope can be identified on a paid claims listing, and the department has received a **completed MAP 100501, Prospective Payment System Rate Adjustment and** Universal Cost Report referenced in paragraphs (a) and (b) of this subsection, and no additional documentation is needed from the FQHC, FQHC look-alike, or RHC, the department shall:

a. Not review a paid claims listing in establishing a new PPS final rate for an FQHC, FQHC look-alike, or RHC resulting from the change in scope; and

b. Establish a new PPS final rate for an FQHC, FQHC look-alike, or RHC resulting from the change in scope within ninety (90) days of receiving the **completed MAP 100501, Prospective Payment System Rate Adjustment and** Universal Cost Report.

Section 11.[9.] Limitations and Exclusions. (1)(a) Except for a case in which a recipient or enrollee, subsequent to the first encounter at an FQHC, FQHC look-alike, or RHC, suffers an illness or injury requiring additional diagnosis or treatment, an encoun-

ter with more than one (1) health care provider or multiple encounters with the same health care provider which take place on the same day and at a single location shall constitute a single visit.

(b) The limit established in paragraph (a) of this subsection shall:

1. Apply to an FQHC, FQHC look-alike, or RHC; and

2. Not apply to a PCC that is not an FQHC, FQHC look-alike, or RHC.

(2)(a) Except as established in paragraph (b) of this subsection, a vaccine available without charge to an FQHC, FQHC look-alike, RHC, or PCC through the department's Vaccines for Children Program and the administration of the vaccine shall not be reported as a cost to the Medicaid Program.

(b) Adult flu vaccine costs shall be allowed as Medicaid costs reported on a Universal Cost Report.

(3) The department shall not reimburse for services provided by an FQHC, FQHC look-alike, **PCC,** or RHC to a recipient in a hospital **unless the FQHC, FQHC look-alike, PCC, or RHC has previously, any time prior to the hospital admission, provided a service to the recipient at the FQHC's, FQHC look-alike's, PCC's, or RHC's location**.

Section 12.[~~10.~~] Out-of-State Providers. (1) Except as established in subsection (2) of this section, reimbursement to an out-of-state FQHC, FQHC look-alike, or RHC shall be based on the rate on file with the FQHC's, FQHC look-alike's, or RHC's state Medicaid agency.

(2) If an out-of-state FQHC's, FQHC look-alike's, or RHC's reimbursement is an APM, the department's reimbursement to the out-of-state FQHC, FQHC look-alike, or

RHC shall:

(a) Not be the APM the FQHC, FQHC look-alike, or RHC receives in its state; and

(b) Be the final PPS rate that the FQHC, FQHC look-alike, or RHC would receive in its state if it were not receiving an APM.

Section 13.[~~11.~~] Federal Approval and Federal Financial Participation. The department's reimbursement for services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the reimbursement; and

(2)[~~A policy established in this administrative regulation shall be null and void if the~~] Centers for Medicare and Medicaid Services' approval for the reimbursement[~~Services:~~

~~(1) Denies federal financial participation for the policy; or~~

~~(2) Disapproves the policy~~].

Section 14. Not Applicable to Managed Care Organizations. A managed care organization shall not be required to reimburse in accordance with this administrative regulation for a service covered pursuant to:

(1)(a) 907 KAR 1:054; or

(b) 907 KAR 1:082; and

(2) This administrative regulation.

Section 15.[~~12.~~] Appeal Rights.[~~(1) An appeal of a negative action taken by the department regarding a Medicaid beneficiary shall be in accordance with 907 KAR 1:563.~~

~~(2) An appeal of a negative action taken by the department regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.~~

~~(3)~~] An FQHC, FQHC look-alike, PCC, or RHC may appeal a department decision as

to the application of this administrative regulation as it impacts the facility's reimbursement rate in accordance with 907 KAR 1:671.

Section 16.[~~13.~~] Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "MAP 100501, Prospective Payment System Rate Adjustment", February 2013 edition;[~~and~~]

(b) "Instructions for Completing the MAP 100501 Form", February 2013 edition;

(c) "Universal Cost Report", May 2015; and

(d) "Universal Cost Report Instructions", May 2015.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.

907 KAR 1:055

REVIEWED:

7-30-15
Date

Lisa Lee, Commissioner
Department for Medicaid Services

APPROVED:

8/13/15
Date

Audrey Tayse Haynes, Secretary
Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 1:055
Contact: Stuart Owen (502) 564-4321

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the Department for Medicaid Services (DMS) reimbursement policies for Medicaid covered services provided by a federally-qualified health center (FQHC), rural health clinic (RHC), or primary care center (PCC) that is not an FQHC, FQHC look-alike, or RHC. An FQHC or FQHC look-alike is a federally-recognized entity that serves a population that is medically underserved. An RHC is a federally-recognized entity that is designated or certified by the secretary of the Department of Health and Human Services as being located in an area that is a health professional shortage area or medically underserved area. A PCC is an entity whose licensure requirements are established by the Cabinet for Health and Family Services Office of Inspector General pursuant to 902 KAR 20:058 and are not federally-recognized as being equivalent to an FQHC.

(b) The necessity of this administrative regulation: The administrative regulation is necessary to establish the Department for Medicaid Services (DMS) reimbursement policies for Medicaid covered services provided by an FQHC, RHC, or PCC (that is not an FQHC, FQHC look-alike, or RHC.)

(c) How this administrative regulation conforms to the content of the authorizing statutes: The administrative regulation conforms to the content of the authorizing statutes by reimbursing for Medicaid covered services provided by an FQHC, RHC, or PCC in a manner which ensures the receipt of federal funding for the reimbursement.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by reimbursing for Medicaid covered services provided by an FQHC, RHC, or PCC in a manner which ensures the receipt of federal funding for the reimbursement.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: The amendment establishes an alternative reimbursement option (an alternative payment methodology or APM) for FQHCs, FQHC look-alikes, or rural health clinics which choose to receive such reimbursement; amends the reimbursement methodology for a new FQHC, FQHC-look-alike, or RHC and elaborates on the process for establishing reimbursement for such a facility; incorporates by reference specific documents – Universal Cost Report and Universal Cost Report Instructions – used in establishing reimbursement for a new FQHC, FQHC look-alike, or RHC; elaborates on the process and requirements related to requesting and establishing a new reimbursement due to a change in scope (of services); establishes that DMS will not pay an APM for an out-of-state FQHC, FQHC look-alike, or RCH; clarifies that managed care organizations are not required to reimburse in the same way for FQHC, FQHC look-alike, or RHC services as DMS reimburses; inserts definitions for clarity; and clarifies miscellaneous provisions.

Amendments in the amended after comments administrative regulation include redefining "base year" to establish that it ends within twenty-four (24) months from when the FQHC, FQHC look-alike, or RHC enrolled in the Medicaid Program; clarifying that an FQHC's, FQHC look-alike's, or RHC's reasonable costs are determined based on cost report data from the FQHC's, FQHC look-alike's, or RHC's base year; clarifying that the Universal Cost Report corresponds to the FQHC's, FQHC look-alike's, or RHC's base year; clarifying that the default reimbursement (when an FQHC, FQHC look-alike, or RHC is delinquent in submitting their Universal Cost Report, documentation, or related information to DMS is DMS's reimbursement for primary care services pursuant to Section 7 of this administrative regulation; clarifying that DMS's reimbursement for physician services for which no code/rate exists on the Kentucky-specific Medicare Physician Fee Schedule and which is provided by an advanced practice registered nurse or physician assistant is seventy-five (75) percent of what DMS pays a physician for the service; allowing a new FQHC, FQHC look-alike, or RHC to receive the alternative payment methodology (APM) for an interim PPS rate if the FQHC, FQHC look-alike, or RHC is receiving an interim PPS rate prior to November 1, 2015; eliminating the requirement that a projected Universal Cost Report be submitted DMS when requesting a change in scope as the MAP 100501 Prospective Payment System Rate Adjustment and Universal Cost Report is used for a change in scope; and clarifying that DMS will reimburse for FQHC, FQHC look-alike, or RHC services provided in a hospital if the FQHC, FQHC look-alike, or RHC provided services to the recipient at the FQHC, FQHC look-alike, or RHC location prior to the recipient being admitted to a hospital (prior relationship has been established).

(b) The necessity of the amendment to this administrative regulation: The alternative reimbursement option (an APM) is necessary to maintain the viability of a handful of FQHCs/RHCs whose current reimbursement is well below the average of others in Kentucky. Reimbursement for these entities is federally mandated. The federally-mandated model (which is customized for each entity) was introduced in 2001, but over time the reimbursement for a few such facilities participating in Kentucky's Medicaid program has proved to be significantly lower than the other entities and is at a level that threatens the viability of the entities. Consequently, DMS proposed to the Centers for Medicare and Medicaid Services (CMS) – the federal agency which oversees and provides federal funding to Medicaid programs – an APM to help sustain the entities and which would be available to all entities. The APM is a rate equal to 125 percent of the Medicare PPS rate for rural health clinics in effect as of September 30, 2014. Any FQHC, FQHC look-alike, or RHC can choose this option; however, DMS only anticipates that the few RHCs whose current prospective payment system (PPS) encounter rate is lower than the alternative will actually choose the alternative. CMS has approved the alternative reimbursement. The amendments regarding interim reimbursement for new FQHCs, FQHC look-alikes, and RHCs are necessary to comply with a mandate by CMS. The elaboration on the process of establishing reimbursement for a new FQHC, FQHC look-alike, or RHC as well as elaboration on changing reimbursement due to a change in scope are necessary for clarity. Not offering the APM option to out-of-state FQHCs, FQHC look-alikes, or RHCs is necessary to ensure that only in-state facilities are eligible for the enhanced reimbursement. Incorporating by reference the Universal Cost Report and Universal Cost Report Instructions is necessary to ensure that entities

use the correct documents to report costs. Other amendments are necessary for clarity. Most of the amendments after comments are necessary for clarity. Defining the "base year" as occurring within twenty-four (24) months of an FQHC's, FQHC look-alike's, or RHC's enrollment in the Medicaid Program is necessary to address a problem of some entities enrolling in the Medicaid Program but never submitting a cost report and for a long time or indefinitely being reimbursed an interim PPS rate. An interim PPS rate is intended to be interim as it does not based on the entity's documented costs. Reimbursing an interim PPS rate for a long time creates problems because if the FQHC's, FQHC look-alike's, or RHC's final PPS rate proves to be lower than the interim PPS rate then the FQHC, FQHC look-alike, or RHC may owe DMS a very large amount of money due to overpayments. DMS has been unsuccessful in some cases in recouping such money.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by helping sustain FQHCs/FQHC look-alikes/RHCs whose current reimbursement is inadequate to survive and in order to ensure Medicaid recipient access to services. The amendment after comments conforms to the content of the authorizing statutes by safeguarding taxpayer monies by not allowing entities to receive an interim PPS rate for a long time or indefinitely.

(d) How the amendment will assist in the effective administration of the statutes: The amendment will assist in the effective administration of the authorizing statutes by helping sustain FQHCs/FQHC look-alikes/RHCs whose current reimbursement is inadequate to survive and in order to ensure Medicaid recipient access to services. The amendment after comments conforms to the content of the authorizing statutes by safeguarding taxpayer monies by not allowing entities to receive an interim PPS rate for a long time or indefinitely.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: There were thirty-five (35) FQHCs/FQHC look-alikes, 152 RHCs, and sixty-four (64) PCCs enrolled in Kentucky's Medicaid Program as of March 2015.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. Any FQHC, FQHC look-alike, or RHC that wishes to receive the alternative reimbursement must submit a written request to DMS expressing the request to receive the alternative reimbursement.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). No cost is imposed.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Any FQHC, FQHC look-alike, or RHC that chooses to receive the alternative reimbursement will receive increased Medicaid reimbursement if the entity's current reimbursement is lesser than the alternative reimbursement.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: The costs of the amendment is indeterminable as it depends on how many, if any, FQHCs/FQHC look-alikes/RHCs elect to receive the APM, and how soon, and upon the difference in current reimbursement for such an entity compared to the APM.

(b) On a continuing basis: The response stated in (a) also applies here.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Federal funds authorized under the Social Security Act, Title XIX and state matching funds from general fund and restricted fund appropriations are utilized to fund the this administrative regulation.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment. Neither an increase in fees nor funding is necessary to implement the amendment.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: The amendment neither establishes nor increases any fees.

(9) Tiering: Is tiering applied? Tiering is not applied as the requirements apply to all regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

Administrative Regulation #: 907 KAR 1:055
Contact: Stuart Owen (502) 564-4321

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(10)(B) and 42 U.S.C. 1396a(a)(30)(A).

2. State compliance standards. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry.

3. Minimum or uniform standards contained in the federal mandate. 42 U.S.C. 1396a(a)(10)(B) requires the Medicaid Program to ensure that services are available to Medicaid recipients in the same amount, duration, and scope as available to other individuals (non-Medicaid.) Expanding the base of authorized behavioral health practitioners will help ensure Medicaid recipient access to services statewide and reduce or prevent the lack of availability of services due to demand exceeding supply in any given area. Similarly, 42 U.S.C. 1396a(a)(30)(A) requires Medicaid state plans to: "...provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? This administrative regulation does not set stricter requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. Neither stricter nor additional standards nor responsibilities are imposed.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative Regulation #: 907 KAR 1:055
Contact: Stuart Owen (502) 564-4321

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by this administrative regulation.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 194A.030(2), 194A.050(1), 205.520(3), 42 U.S.C. 1396a(a)(10)(B), 42 U.S.C. 1396a(a)(30)(A).

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? DMS projects no revenue will initially be generated by the amendment to this administrative regulation.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? DMS projects no revenue will be generated in subsequent years by the amendment to this administrative regulation.

(c) How much will it cost to administer this program for the first year? The costs of the amendment is indeterminable as it depends on how many, if any, FQHCs/FQHC look-alikes/RHCs elect to receive the alternative reimbursement, and how soon, and upon the difference in current reimbursement for such an entity compared to the alternative reimbursement.

(d) How much will it cost to administer this program for subsequent years? The response stated in (c) also applies here.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):

Expenditures (+/-):

Other Explanation